Wylie Children's DENTISTRY

Welcome to Our Practice!

Child's Name: _____ Child's Date of Birth: _____

Emergency Contact (not parent) name and phone number: _____

How did you hear about our office?

- ○ Friend (Name) _____
- ○ Drive-By
- ○ Tooth Fairy School Presentation
- ○ Tooth Fairy Event or Fair
- ○ Google or other search engine
- ○ Billboard
- ○ Sibling is a patient already
- ○ Other Dentist (Name)_____
- ○ Pediatrician (Name)_____
- ○ Insurance Referral
- ○ Our Website
- ○ Online Yellow Pages
- ○ Other_____

Person(s) Responsible for Account

Mother's Information: (Circle one) Mother Step-Mother Foster Mother Legal Guardian Grandmother

Name:	Date of Birth:	Occupation:
Address:	Social Security #	Employer:
City, State, Zip:	Marital Status:	Does child live with you?
Home Phone:	Cell/Mobile Phone:	Work Phone:
Email Address:		

***What is the best number to contact you for confirmations? (Please circle one) Home Work Cell

Father's Information: (Circle one) Father Step-Father Foster Father Legal Guardian Grandfather

Name:	Date of Birth:	Occupation:
Address:	Social Security #	Employer:
City, State, Zip:	Marital Status:	Does child live with you?
Home Phone:	Cell/Mobile Phone:	Work Phone:
Email Address:		

***What is the best number to contact you for confirmations? (Please circle one) Home Work Cell

520 w. Brown St. Suite B • Wylie, TX 75098 972-429-7070

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Patient Information

Patient's Name: _____ Date: _____
First MI Last

Gender: _____ Nickname: _____ Child's favorites (pet, toy, friend) _____

Birthdate: _____ Phone (to confirm appointments) _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Previous DDS: _____ Date of last dental visit: _____ Reason for this visit _____

Times a day child brushes: _____ Times a week child flosses: _____ Is your water fluoridated? _____

How would you rate your child's smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

Times a day child brushes: _____ Times a week child flosses: _____ Is your water fluoridated? _____

Does the child do any of the following?

- ○ Thumb/Finger Sucking
- ○ Heavy Snoring
- ○ Breast feeding
- ○ Tongue Thrusting/Sucking
- ○ Mouth Breathing
- ○ Bottle at Bedtime
- ○ Grinding Teeth
- ○ Lip Sucking/Biting
- ○ Pacifier

Does the child have or ever had any of the following diseases, medical conditions, or procedures? Please check those that apply: (By checking "NONE" you agree that you have read ALL conditions and that NO conditions currently apply to the child.)

- ○ Allergies Environmental
- ○ Allergic to Medication
- ○ Allergies Food/Dye
- ○ Aids/HIV/ARC
- ○ Anemia
- ○ Autism
- ○ Asthma or Lung Problems
- ○ Birth Defects _____
- ○ Cancer/Tumors
- ○ Cerebral Palsy
- ○ Diabetes
- ○ Difficulty with Speech
- ○ Epilepsy/Seizures
- ○ Excessive Bleeding
- ○ Cleft Lip/Palate
- ○ Hearing Problems
- ○ Hyperactivity/ADHD/ADD
- ○ Hospitalization/Surgery
- ○ Head Injuries
- ○ Heart Disease
- ○ Heart Murmur
- ○ Hepatitis (A,B,C)
- ○ High Blood Pressure
- ○ Jaundice
- ○ Kidney Disease
- ○ Liver Disease
- ○ Mental Disorders
- ○ Mouth Injuries
- ○ Latex Allergy
- ○ Leukemia
- ○ Radiation Treatment
- ○ Respiratory Problems
- ○ Rheumatic Fever
- ○ Rheumatoid Arthritis
- ○ Sinus Problems
- ○ Stomach Problems
- ○ Stroke
- ○ Tuberculosis TB
- ○ Artificial Bones/Joints
- ○ Ulcers
- ○ Prolonged Bleeding
- ○ Codeine Allergy
- ○ Penicillin Allergy
- ○ Other

Please explain any checked responses...

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

- ○ None

List all current medications: _____

List any allergic reactions to medications: _____

Is the child taking any of the following medications?

- ○ Pain Medications (Including Asprin)
- ○ ADD/ADHD Meds
- ○ Blood Thinners
- ○ Tranquilizers
- ○ Insulin
- ○ Muscle Relaxers
- ○ Others: _____

Name of Physician: _____ Telephone Number: _____

Date of most recent medical examination: _____ Child's Current Weight: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is ever any change of health, I will inform Wylie Children's Dentistry at the next appointment without fail.

_____ Date: _____
Signature of patient, parent, or guardian

Financial Agreement

Child's Name: _____ Child's Date of Birth: _____

We appreciate you choosing our office for your child's dental care. At Wylie Children's Dentistry, we value our relationship with your family and would like to offer the following as our payment policy.

If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. Your insurance benefits are a contract between you and your employer. The amount of coverage you receive will depend on the quality of the plan purchased by your employer, not the fees of Wylie Children's Dentistry.

In case of insurance, we will be happy to help you receive the maximum benefits available under your policy. As a courtesy, we will file your insurance benefits for you after every visit. However, please realize that the relationship is between you, the insured, and your insurance company.

If we do not receive payment from your insurance company within 60 days after submission of claim, you will be required to pay for all dental services in full.

Once the treatment plan and estimated insurance benefits are reviewed with you, we ask that you pay your out of pocket portion in full at the time of service.

If you are ever unable to keep a cleaning and check-up appointment, please call us at least 72 hours in advance to reschedule in order to avoid a $50 no show fee.

If you are ever unable to keep a TREATMENT appointment, please call us at least 72 hours in advance to reschedule in order to avoid a $75 no show fee.

Please note that parents or guardians bringing the child into the office on the day of the service will be expected to pay for services rendered.

I have read and understand the payment policies for the office:

*_____ *_____

Parent/Guardian Name (printed) Parent's/Guardian's Signature

*_____

Date

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Parental Guidelines in Our Office

Child's Name: _____Child's Date of Birth: _____

Dear Parents,

As a parent we know how much time you've spent in your child's physician's office and we, as dentists, share some similarities with them, most notably seeing several patients throughout the day for non-invasive procedures. The most notable difference is that a physician will perform his invasive surgeries in an outpatient setting or a hospital where only staff and doctors are present. A dentist performs his surgical and operative procedures in the same area and at the same time our non-invasive patients are seen. The dentist requires the same level of concentration given the physician in his controlled environment. Minimum movement and distractions in and about the operative area are crucial for optimum care of the children. During oral sedation appointments, parents may check on the patient from the hallway as many times as they would like, but are not allowed to sit in the room for the procedure. NO parents will be allowed in the clinical area during IV sedation.

You may choose whether or not to accompany your child to his/her cleaning check-up appointment. Although we sense some children do better without parents present, we are open to having you present with your child. If you choose to be present, we suggest the following guidelines to improve chances of a positive outcome:

You can assist us by following a few guidelines:

1. Allow us to prepare your child
2. Be supportive of the practice's terminology
3. Please be a SILENT OBSERVER. That means no talking during dental procedures. Support your child with touches
    a. This allows us to maintain communication with your child
    b. Children will normally listen to their parents instead of us and may not hear our guidance
    c. You might give incorrect or misleading information
4. If asked to leave, be ready to immediately walk away
    a. Many children will try to control the situation
    b. "Acting out" is normal, but unacceptable and unsafe during your child's visit to our office
    c. This is intended to "short circuit" the control attempt
    d. We will continue to support your child at all times

Following these few simple guidelines will help to insure the best possible results.

I have read the above information and have been explained the office policy on parental presence in the clinical area.

Parent/Guardian Signature:*_____

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Medical/Dental Release Statement

Child's Name: _____ Child's Date of Birth: _____

I give my consent for the doctor on staff for Wylie Children's Dentistry to do a complete and thorough examination on the patient previously named, including any diagnostic radiographs needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to inform Wylie Children's Dentistry of any future changes to my child's medical status. As the parent or legal guardian of the previously named patient, I do hereby grant the doctor and his staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.

Requirement for Filing Insurance Claims: To precipitate the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within 60-days of treatment. I hereby authorize payment of insurance benefits directly to Wylie Children's Dentistry. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

I will follow all post-operative instructions and if my child is sedated for treatment I will review aftercare instructions and follow doctor's directives to insure recovery of my child. Any emergencies after hours I have been advised to go to the emergency room nearest me.

I have been informed to call the office at 972-429-7070 and follow prompts to let after hours clinical employee on call know that I have taken my child to the emergency room.

*_____ *_____

Parent/Guardian Signature Date

HIPAA Consent Agreement (Privacy Act)

You may refuse to sign this agreement

This is for the Treatment, Payment, and Communication between other healthcare professionals.
I give consent for the Use and Disclosure of Health Information of myself and or my dependent for the purpose of Treatment, Payment, and/or Communication between other healthcare professionals. I understand and have been provided with a copy of this office's Notice of Privacy Practices that provides a more complete description of health information uses and disclosures. I understand that I have the right to review a copy of this office's Notice of Privacy Practices prior to signing this condensed form.

*_____ *_____ *_____

Please Print Name Signature of Parent or Guardian Date

Below this line is For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign
_____Communication barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement

Date: _____ Staff Signature:_____

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